

Determination of **Reasonable Charges**

Under Part B of Medicare

A Basic Text

Social Security Administration
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Introduction

This booklet, Determination of Reasonable Charges Under Part B of the Medicare Program, is designed for individuals who have a general knowledge of Medicare and its provisions. This handbook should in no way be considered as a policy guide. Its purpose is to impart an understanding of the reasonable charge provision of the supplementary medical insurance program and its application in paying Medicare benefits for physicians' and other suppliers' services. It is divided into three parts as follows:

Part 1 - Summary

The Summary is written in simple and straightforward language and, as the name implies, it summarizes the basic procedures involved in the determination and use of reasonable charges. This part of the booklet may be especially useful for explaining reasonable charges to beneficiaries.

Part 2 - Footnotes

The Footnotes part of the booklet examines the procedures covered in the Summary in greater detail. The language is somewhat technical since precision of meaning is necessary. This part of the booklet is intended for anyone who wishes to reach a deeper understanding of the intricacies of reasonable charges.

Part 3 - Glossary

The Glossary contains explanations of some of the more frequently used terms in this booklet.

PART 1 - A SUMMARY OF THE BASIC

REASONABLE CHARGE METHODOLOGY

(All footnotes follow this summary in Part 2 - Footnotes.)

- I. When the Congress was considering the legislation which later became the Medicare law, it considered carefully the question of the best method of making payments for services of physicians and to suppliers of other medical services and items and equipment covered under the Medicare program. After studying various methods which could have been used, the Congress decided that the method which the law terms the "reasonable charge" method would best serve the needs of the people who would be affected by the program.¹
- II. Under the Medicare law, the carriers that process and pay claims for Medicare Part B services are responsible for insuring that payments are based on the "reasonable charges" for physicians' and suppliers' services. However, the basic methods and procedures used by carriers in determining reasonable charges must be consistent with Medicare law, regulations, and the policy guidelines issued by SSA to implement them.²
- III. Medicare will make payments for physicians' and suppliers' covered services³ after the beneficiary has paid the first \$60 of reasonable charges for those services each year. The first \$60 is the "deductible." Medicare pays 80 percent of the "reasonable charge" for covered services after the deductible has been met. The beneficiary is responsible for the remaining 20 percent.
- IV. The "reasonable charge" for a physician's or a supplier's service is the lowest of three kinds of charges--the actual charge, the physician's or supplier's customary charge, and the prevailing charge.⁴ The actual charge is the charge that the physician or supplier billed for his service. The customary charge is the charge the physician or supplier usually bills most of his patients for the same service. The prevailing charge is the lowest charge high enough to include at least three-fourths of the bills for the same service billed by all the physicians or suppliers in the same area. Whichever one of these three charges is the lowest is called the "reasonable charge." For instance, let us say that the prevailing charge for a service in the area where Dr. Ames practices is \$20 and Dr. Ames usually charges \$18 for that service (his customary charge). Then, if he bills \$21 for that service (his actual charge), the "reasonable charge" for that service would be the lowest of the three charges--\$18. This is why a "reasonable charge" may be lower than what the doctor billed for.
- V. The data from which the customary and prevailing charges are established are collected during a calendar year (January 1 to December 31).⁵ Customary and prevailing charges are revised at the beginning of each fee screen year based on the charge information collected during the preceding calendar year. For example, fee screen year 1977 (July 1, 1976 to June 30, 1977) prevailing charges were based on

calendar year 1975 (January 1, 1975 to December 31, 1975) charge information. There are several reasons for this lag in the Medicare program's recognition of fee increases, and for not updating the allowances more frequently. One is that a charge must be made over a period of time before it can meet the requirement that it be "customary." Also, the statistics on charges on which the carriers' allowances are based must be collected over a period, and at the end of that period the data must be tabulated and analyzed before they can be put into effect. Finally, were Medicare to recognize increases in charges as quickly as they are made, Medicare might lend support to a rapid escalation of the rates.

- VI. The customary charge is the amount which best represents the charge usually made by a particular physician or supplier for a specific medical service.⁶ The term "best represents" means that if Dr. Brown charged \$7 for the same service 80 times during a calendar year, \$6 twice, and \$8 three times, \$7 would "best represent" the charge usually made to his patients for that service.
- VII. In calculating the customary charge screens to be used during a fee screen year, each charge the physician or supplier has made for a particular service during the preceding calendar year is listed by the carrier in ascending order. The lowest charge on the list which is high enough to include at least half of the listed charges is then selected as the customary charge for the service.⁷
- VIII. The carrier computes the prevailing charge after looking at all charges made for similar services by all the physicians or suppliers within a certain locality. (See paragraph XI) The prevailing charge is calculated by finding the customary charge high enough to include at least three-fourths of the "weighted" customary charges of all physicians or suppliers rendering that particular service in the locality. This prevailing charge establishes an overall limitation on the charges which the carrier accepts as reasonable for a specific procedure or service, except where unusual circumstances or medical complications call for a higher charge.⁸
- IX. The procedure for establishing the prevailing charge is illustrated by the following example:

<u>Customary Charge for Office Visit*</u>	<u>Number of Office Visits (Weighting)</u>	<u>Cumulative Number of Office Visits</u>
\$5	1402	1402
\$6	1115 (+ 1402 =)	2517
\$7	1680 (+ 2517 =)	4197
\$8	803 (+ 4197 =)	5000

*All physicians within the locality.

In the above example, three-fourths of the total number of office visits (5000) equals 3750 visits. The prevailing charge in this case is the customary charge listed for the 3750th visit, which falls among the \$7 charges. Therefore, \$7 is the prevailing charge.⁹

X. In 1972 Congress decided to let Medicare prevailing charges go up only as much as inflation in general. This limit was the so-called "economic index." The economic index for fiscal year 1976 was 17.9 percent. The economic index only limits how much Medicare prevailing charges may increase above 1973 levels. In fiscal year 1976 Medicare prevailing charges were allowed to increase up to 17.9 percent above their fiscal year 1973 levels. Incidentally, the economic index is only applied to prevailing charges. In other words, only if the charge the physician bills and his customary charge are higher than the prevailing charge where the physician practices will the "reasonable charge" possibly be cut back by the economic index.¹⁰

XI. In calculating the prevailing charge for a service "in the locality," carriers use charge data from that locality. A locality will usually be a subdivision of a State, which includes a cross-section of the population.¹¹ Single "localities" have sometimes been developed by combining all areas in a region classified as "metropolitan," "urban," or "rural" areas or by combining areas with similar charge patterns. Other carriers, particularly the ones serving sparsely populated states, have found that there is very little variation in charge patterns within their service areas and so the whole service area of each of those carriers is treated as one locality. Separate prevailing charges in a locality have also been recognized by the carriers for physicians in different kinds of specialty practice.^{12,13,14} Medicare payments for the same service, therefore, may vary from one locality to another and from one physician to another in the same locality. This payment variation reflects the patterns of charges that physicians and suppliers of services¹⁵ have themselves established over time.

XII. In addition to establishing the customary and prevailing charge criteria for judging the reasonableness of a charge, the law says that the reasonable charge for a service may not be higher than the allowable charge applicable to the carrier's own policyholders for a comparable service under comparable circumstances.¹⁶

XIII. Physicians and suppliers may choose to "accept assignment" of a beneficiary's claim. Under this provision of the Medicare law, the beneficiary need not pay any difference between what the physician or supplier actually charges and what is determined to be the reasonable charge for his services. When the physician or supplier bills Medicare directly and agrees to accept assignment of the Medicare Part B claim, he must then agree to accept Medicare's determination

of the reasonable charge as his total charge. Medicare then pays the physician or supplier 80 percent of the reasonable charge. The physician or supplier may charge the beneficiary for only the remaining 20 percent of the reasonable charge. For example, if the physician or supplier accepted assignment of a claim and the reasonable charge was \$18 for the service for which the physician or supplier billed \$21, he would be paid \$14.40 (80 percent of \$18) by Medicare and he can charge the beneficiary only for \$3.60 (20 percent of \$18). The physician or supplier would not be allowed to charge the beneficiary for the other \$3 of the original bill (\$21 - \$18 = \$3). On the other hand, if the physician or supplier will not accept assignment of the claim, he may charge the beneficiary for the \$3.60 (20 percent of \$18) and for the remaining \$3 of the original bill. Medicare does not pay for services not covered by Medicare whether or not the claim is assigned.

PART 2 - FOOTNOTES

1. The reasonable charge is the basis of payment under the supplementary medical insurance program for medical and other health services furnished by physicians, medical groups, independent laboratories, suppliers of ambulance services, and suppliers of durable medical equipment, prostheses, etc.
2. In the administration of the medical insurance program, the carrier has primary responsibility for determining reasonable charges. The careful determination of reasonable charges in a way which is equitable both to those rendering the services and to those paying the premiums is a very important responsibility. The possible impact on fees charged the general public is a matter of broad concern that should be considered in applying the criteria for determining reasonable charges. The amount of future premiums under the medical insurance program will be directly affected by carrier performance in determining reasonable charges.

The reasonable charge determinations made by carriers are not normally reviewed by the Social Security Administration on a case-by-case basis. However, the Social Security Administration has an overall responsibility for the administration of the supplementary medical insurance program. The basic methods and procedures used by carriers in determining reasonable charges must therefore be consistent with the law, the regulations, and the broad principles and policy guidelines issued by the Social Security Administration.

3. Any individual who is enrolled under the supplementary medical insurance plan established by Part B is entitled to have payment made to him, or on his behalf, for certain medically reasonable and necessary medical and other health services. Subject to certain conditions, limitations, and exclusions, payment may be made for physicians' services (including diagnosis, therapy, surgery, consultations, and home, office, and institutional calls); for home health services for up to 100 visits furnished by a participating home health agency during a calendar year; for services and supplies, including drugs and biologicals which cannot be self-administered, furnished as an incident to a physician's professional service, and of kinds which are commonly furnished in a physician's office or clinic and are commonly either rendered without charge, or included in the physician's bill; for hospital services and supplies (including drugs and biologicals which cannot be self-administered) incident to physicians' services rendered to outpatients; for diagnostic X-ray tests (including portable X-ray tests), diagnostic laboratory tests, and other diagnostic tests; for X-ray therapy, radium therapy, and radioactive isotope therapy (including materials and services of technicians administering

such therapies); for surgical dressings, and splints, casts and other devices used for reduction of fractures and dislocations; for rental or the purchase of durable medical equipment, including iron lungs, oxygen tents, hospital beds, renal dialysis systems, and wheelchairs used in the patient's home; for prosthetic devices (other than dental) which replace all or part of an internal body organ, including replacement of such devices (including colostomy bags and supplies directly related to colostomy care), also including certain renal dialysis facility dialysis services; for leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition; for ambulance services when the use of other means of transportation is contraindicated by the individual's condition; for outpatient hospital diagnostic services including drugs and biologicals required in the performance of such services which are: (1) furnished to outpatients by a hospital (or by others under an arrangement made by a hospital); and (2) ordinarily furnished by such hospital (or under such arrangements) to its outpatients for the purposes of diagnostic study; for outpatient physical therapy and speech pathology services which are furnished by or under arrangements made by a participating clinic, rehabilitation agency, public health agency or other provider of services; and for outpatient physical therapy services which are furnished by or under the direct supervision of a qualified physical therapist in independent practice in his office or in the individual's home.

4. The two criteria set out in the Medicare law (section 1842 of title XVIII) which must be considered in determining the reasonable charge for a service are: (a) the customary charge for similar services generally made by the physician or other person furnishing such services; and (b) the prevailing charge in the locality for similar services. Therefore, the reasonable charge for a specific service, in the absence of unusual medical complications or circumstances, may not exceed the lowest of: (a) the physician's or other person's customary charge for that service; (b) the prevailing charge made for similar services in the locality; or (c) the actual charge of the physician or other person rendering the service. A charge which exceeds the customary charge or the prevailing charge in the locality, or both, may be found to be reasonable if unusual circumstances or medical complications requiring significant additional time, effort, or expense are such as to actually constitute a distinguishably different service. The law also provides that the reasonable charge for a service may not exceed the charge applicable for a comparable service and under comparable circumstances to the policyholders or subscribers of the carrier. Also, under the law, other factors that may be found necessary and appropriate with respect to a specific item or service to use in judging whether the charge is inherently reasonable, should be taken into account.

The income of the individual patient may not be considered in determining the amount of the reasonable charge. Consideration of a patient's income in determining the reasonable charge could be looked upon as an inverse means test--this is, it would result in a situation under which the Medicare program would pay more for beneficiaries with high incomes than it would pay for beneficiaries with low incomes. There is no provision in the Medicare law for a carrier to evaluate the reasonableness of charges in light of an individual beneficiary's economic status.

5. The customary and prevailing charge limits used by the carriers are updated as early as possible at the beginning of each fee screen year (the 12-month period beginning July), using the available statistics on charges physicians and other persons have made for services derived from claims processed or from claims for services rendered during all of the immediately preceding calendar year. For example, the limits used during fee screen year 1977 (July 1, 1976 - June 30, 1977) were based on the charges made in calendar year 1975. Once the carrier has made a general update of its customary and prevailing charge screens for a fee screen year, further revisions in these screens are not made during that fee screen year, except (1) where there are equity considerations as described later; or (2) to correct erroneous calculations; or (3) to establish screens for new physicians/suppliers or new services.
6. The customary charge is the amount which best represents the actual charges made for a given medical service by a physician to his patients in general, or by other persons who supply other medical and health services to the general public. The carrier therefore obtains information on the customary charges of physicians and other persons not only from the Medicare program, but from other available sources, e.g., from its own programs, from other insurance programs, from the Federal Employee Health Benefit Program, from CHAMPUS, from any studies conducted by State or local medical societies, and from public agencies. It also may ask physicians or other persons for their charges for services rendered to the public in general where the carrier decides that circumstances will permit this.
7. In calculating the customary charge for a certain physician or supplier for a given service, each charge the physician or other supplier has made for that service is arrayed in ascending order. The lowest actual charge which is high enough to include the median of the arrayed charge data is then selected as the physician's or other supplier's customary charge for the service. However, where the charges generally made by a physician or other supplier to other patients are lower than those made to Medicare beneficiaries, the lower charges are to be used as the basis for establishing the Medicare reasonable charge screen.

Generally, when an established physician moves his practice either to an area serviced by a different carrier or to a different locality serviced by the same carrier, there will already be an established customary charge screen for his services. Therefore, the customary charge screen in use before the physician moves his practice may also be used in his new location. If the physician moves to an area serviced by a different carrier, the new carrier may request the customary charge screen from the old carrier. However, at the request of the physician, the carrier may establish a new customary charge screen at the 50th percentile level, provided it has determined that the charge levels or costs of practice in the new area or locality are substantially higher than those in the old area or locality.

In some instances, a new physician will join with one or more established physicians who either already have a group customary charge or who wish to establish a group customary charge. When the customary charge screen for a new physician is established at the 50th percentile level, the carrier will not include these deemed customary charges in the calculation of the group customary charge screen. However, the carrier applies the group customary charge screen in determining reasonable charges for all services the new physician renders as a member of a medical group that has established the custom of charging uniform fees without regard to which member of the group provides the service.

8. Prevailing charges are those charges which fall within the range of charges that are most frequently and widely used in a locality for a particular procedure or service. For any fee screen year, the prevailing charge limit in a locality for a service is calculated as the 75th percentile of the customary charges determined for that service (if allowable under the economic index limitation). In this calculation, each customary charge for the service is arrayed in ascending order and weighted by how often the physician or other person rendered the service (as reflected by the charge data the carrier used to calculate the customary charge). The lowest customary charge which is high enough to include the customary charges of the physicians or other persons who rendered 75 percent of the cumulative services is then determined as the prevailing charge for the service (subject to the economic index limitation).
9. Where it is necessary to establish customary charges through the use of price lists, these customary charges are used to also establish the required prevailing charge limits. In this regard, if a carrier cannot derive precise data on the frequency of services from its records, it may use any information it has about the volume of business done by various suppliers in its area in order to weight the customary charges used to calculate the prevailing charges.

When a carrier does not have adequate statistics on charges for all of a calendar year, e.g., for suppliers of medical equipment, prosthetics, ambulance services, or for new services, the fees charged and the price lists in effect as of June 30 of that calendar year only may be used. The intent is to use a price list which can reasonably be assumed not to exceed the median of the prices charged by the supplier for his items and services during that calendar year.

Once a carrier has established the customary charge screens for a fee screen year, further increases (other than to correct errors) are permitted only in individually identified and highly unusual situations where equity clearly indicates that the increases are warranted. Where a carrier has permitted an increase in a customary charge in such situations, the increased amount is recognized as the customary charge for the next fee screen year if it exceeds the median of the charges made by the physician or other person for the service during the calendar year immediately preceding the start of that fee screen year.

Physicians who begin a new practice may include (1) physicians beginning their first practice, and (2) established physicians who change their practice either to an area serviced by a different carrier or to a different locality serviced by the same carrier. The customary charge for each service rendered by a new physician will be based on the 50th percentile of the weighted customary charges the carrier used to establish the prevailing charge in the locality for the same service and specialty group. The use of the 50th percentile of weighted customary charges guarantees that the new physician is in a position whereby the carrier's customary charge screen for a service he renders will be set at a level which is no lower than the customary charges of established physicians in the locality with the same specialty status who rendered at least 50 percent of such services.

Payment under Part B for a service rendered by a new physician will be based on the lowest of (1) the actual charge made for the service by the physician, (2) his customary charge for the service established at the 50th percentile level, or (3) the applicable prevailing charge for the service. The customary charge screen for a new physician should be maintained at the 50th percentile level until the carrier (1) makes a general revision of its reasonable charge screens at the beginning of a new fee screen year, and (2) has 3 months charge experience for the new physician derived from the same base year in which charge data is taken to calculate the customary charge screens for established physicians. When 3 months charge data is available at the time of a general revision of a carrier's reasonable charge screens, the 50th percentile limitation is no longer applicable and the customary charge screen for the services of the physician is established based on the median of these charges.

10. The Medicare law provides that prevailing charge levels used in determining Medicare reasonable charges for physicians' services may be increased above the level for fiscal year 1973 only to the extent determined to be justified by the Secretary on the basis of appropriate economic index data. The economic index figure will be furnished by the Bureau of Health Insurance to all carriers. The economic index limitation will apply only to increases in prevailing charges and only to physicians' services. It will not affect carriers' customary charge calculations. The law established the Medicare carriers' prevailing charge screens for fiscal year 1973 (that were based on physicians' charge levels during calendar year 1971) as the base for measuring all future increases. The economic index calculated for each fee screen year will, therefore, reflect on a cumulative basis the changes that have taken place in physicians' practice expenses and in general earnings levels since calendar year 1971.
11. Prevailing charges are those charges which fall within the range of charges that are most frequently and widely used in a locality for a particular procedure or service. For the purpose of making reasonable charge determinations, a locality is the geographic area for which the carrier is to derive the prevailing charges for procedures and services. Usually a locality will be a political or economic subdivision of a State and must include a cross-section of the population with respect to economic and other characteristics. Where people tend to gravitate toward certain population centers to obtain medical care or service, localities may be recognized on a basis constituting medical service areas (interstate or otherwise), comparable in concept to "trade areas."

Carriers delineate localities on the basis of their knowledge of local conditions. The localities may differ in population density, economic level, and other major factors affecting charges for services. However, localities are not so finely made that they would include only limited areas or small population groups (e.g., a very rich or very poor neighborhood). Where appropriate, different localities should be established with respect to different types and levels of services. For example, a carrier may determine that a State has five localities for general practitioners' charges, but only one locality (the entire State) for members of a particular specialty group. This might happen where there are not enough members of the specialty group in any one of the five localities to establish a valid basis for deriving the prevailing charges for their services for any one locality.

12. Charging practices in a locality may be different for physicians who practice different specialties; e.g., general practitioners, internists, etc. Existing variations in the level of charges between different

kinds of practice or service could, in some localities, lead to the development of more than one prevailing charge screen. Carriers are responsive to the existing patterns of charges made by physicians in the service area and therefore establish separate prevailing charges for different specialties, but only where this would be in accord with actual practice. For example, a cardiologist may charge \$25 for a specific examination while a general practitioner's charge is \$15 for a similar examination. Both charges are customary for each physician and fall within their respective ranges of prevailing charges in the locality. Thus, the charges made by each of these physicians may be accepted as reasonable charges.

13. Anesthesiologists provide their services during surgical procedures. Traditionally, this specialty practice has charged and has been paid through the use of relative value studies and conversion factors. Frequently, State societies of anesthesiologists establish both the relative value units and conversion factors to be used by its members. In billing for their services, these physicians have identified two elements, one representing the skill, risk, etc. involved in the operation (the base value) and the other representing the length of time of the operation. (Time units are usually counted in 15-minute intervals.)

For example, a relative value study entry for an appendectomy might show:

3621 - appendectomy
Value - 40
Anesthesiologist 4 + T.

Explanation: The relative value for the surgery is 40. The base value for the anesthesiology is 4 units with an additional unit added for each 15 minutes of time for the operation. A 45-minute appendectomy then would have a value of 7 (base-4, time-3 (three 15-minute periods)).

In establishing reasonable charge limits for these services, carriers are expected to develop a median customary charge for each anesthesiologist from his accumulated charge experience. The carrier could also establish a conversion factor by accurately recording the basic relative value units and time relative value units for the procedures on which each anesthesiologist rendered his service. This data together with the actual charges for the procedures made by these anesthesiologists would yield the conversion factors. The prevailing charge screen would be established as a conversion factor based on the 75th percentile of the customary charge conversion factors.

14. Physicians had for some time been faced with the problem of determining a fair value for their services. One method of identifying the relative value of each procedure or service provided by physicians is called a Relative Value Study. It is a means of taking a medical or surgical procedure and assigning a numerical value to it, relative to some basic procedure. This numerical value is called the relative value. Generally, a relative value study is composed of several distinct sections dealing with surgery, radiology, pathology or laboratory services, and medical services - physician visits, examinations, consultations, etc. The values assigned to the procedures in each of these sections are not related to the values in the other sections. To arrive at a fee, for the physician, (or the reasonable charge, for a carrier,) the relative value is multiplied by a conversion factor which is a dollar amount. Either is chosen on the basis of estimate or analysis of data.

The relative value study has several advantages for not only Medicare but other third-party payers. These advantages are:

(1) the narrative description of the various medical and surgical procedures provide a standard definition of these procedures enabling physicians to describe their services in a manner readily understandable by carriers;

(2) the numerical codes assigned to each procedure provide a readily usable description of the procedure for computer operations; and

(3) the relative value units when used with appropriate conversion factors provide a means for pricing services when gaps exist in the reasonable charge screens.

In the early days of Medicare, carriers often used the relative value studies as a basis for reasonable charge determinations. That is, the carrier would establish a dollar conversion factor which it determined to be representative of the prevailing pattern of physician charges for use with the appropriate relative value units.

To illustrate the development and use of a relative value study let's look at a simplified example.

A medical society appoints a panel of its members to study the problems of establishing some means of assisting its members in describing their services and in setting their fees. In the medical section (physician nonsurgical services) the panel chooses as the basic procedure to which all others in this section will be compared, the

routine followup office visit and it assigns to this procedure the value of "1." In making this determination the physicians working on the relative value study apply a mixture of statistical data and professional judgment. Now then, the time, skill, and effort to make a comprehensive diagnostic history and examination is judged by the physician panel as being six times that which goes into a routine followup office visit. Thus, the relative value for that service is six units.

A physician in determining his fee, (or a carrier in computing its benefit payment), multiplies the relative value units by a conversion factor to arrive at a fee (or benefit payment). The physician determines his conversion factor on the economics of his practice; the carrier determines its conversion factor after analyzing all claims for the procedures in the medical section.

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MEDICINE

General Information and Instructions

1. The following visits, examinations, consultations and similar services are the most frequently recurring and widely variable items of medical care. The time requirements of these services range from the briefest possible contact with the patient to the time-consuming interview and exhaustive examination needed to appraise a complex medical problem. The following gradation of services is listed in an attempt to reflect the relative values of the various times and skills required. These services may be employed for care of illness or health supervision.

Health supervision does not involve as a primary purpose the diagnosis and treatment of illness. Its purposes include an appraisal of the individuality and developmental level of the patient and the promotion of optimal health and personality growth as well as the prevention of illness. These services are included in items 9000 through 9030 in accordance with time and complexity of the services rendered. (See 9050, et seq. for psychiatric services.)

2. (†): Those items preceded by a (†) may be used by all physicians, but are to be used when the problem appears to be of a serious or difficult nature requiring additional time and/or special study, e.g., Internal Medicine, Pediatrics, Neurology, etc. Written reports shall be furnished upon request.

3. "Sv." Items: "Sv." in the value column indicates the value is to be calculated as the sum of the various services rendered, (e.g., office, home, nursing home or hospital visit, consultation or detention, etc.) according to the ground rules covering those services.

4. Medical care of an unusual or unlisted value may occur which represents a type of service over and beyond listed procedures. If substantiated "By Report" (see Rule 5), additional unit values may be warranted.

5. "BY REPORT": When the value of a procedure is to be determined "By Report," information concerning the nature, extent and need for the procedure or service, the time, the skill and the equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary.

6. "INDEPENDENT PROCEDURE": Certain of the listed procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate charge. When such a procedure is carried out as a separate entity, not immediately related to other services, the indicated value for "Independent Procedure" is applicable.

7. Values for mileage, night calls, Sunday and holiday calls, preparation of special reports, etc., are listed under "Other Services" in this section (Items 9070-9075).

8. Necessary drugs, supplies and materials provided by the physician may be charged for separately.

9. Values for other diagnostic, therapeutic, surgical, anesthesia, x-ray and laboratory procedures are listed in the sections entitled "Surgery," "Anesthesia," "Radiology" and "Laboratory."

OFFICE VISITS

	Value
9000 INITIAL office visit, ROUTINE, new patient or new illness, history and examination.....	2.0
†9001 INITIAL (or subsequent) office visit, COMPLETE diagnostic history and physical examination, ESTABLISHED PATIENT OR MINOR CHRONIC ILLNESS, including initiation of diagnostic and treatment programs	8.5
†9002 INITIAL (or subsequent) office visit, COMPLETE diagnostic history and physical examination, NEW PATIENT OR MAJOR ILLNESS, including initiation of diagnostic and treatment programs.....	6.0

†See this page, Rule 2, to calculate value of this service.

PHYSICIAN COMPLIANCE OPTIONAL ■

MEDICINE

RULES; VISITS; CONSULTATIONS

9000-9027

	Value
9003 FOLLOW-UP office visit, BRIEF; e.g., routine injection, minimal dressing, etc.....	0.8
9004 FOLLOW-UP office visit, ROUTINE	1.0
†9005 FOLLOW-UP office visit necessitating professional care OVER AND ABOVE routine visit.....	1.5
†9006 FOLLOW-UP office visit, PROLONGED, over and above 9005	2.0
†9007 FOLLOW-UP office visit necessitating COMPLETE re-examination and re-evaluation of patient as a whole (continuing illness).....	3.0
†9008 RE-EXAMINATION, comprehensive diagnostic history and re-evaluation, established patient, (annual type)	4.0

HOME or NURSING (CONVALESCENT) HOME VISITS

9010 INITIAL home visit, ROUTINE, new patient or new illness, history and examination.....	2.5
†9011 INITIAL home visit, COMPLETE diagnostic history and physical examination, ESTABLISHED PATIENT OR MINOR CHRONIC ILLNESS, including initiation of diagnostic and treatment programs.....	4.0
†9012 INITIAL home visit, COMPLETE diagnostic history and physical examination, NEW PATIENT OR MAJOR ILLNESS, including initiation of diagnostic and treatment programs.....	7.0
9013 FOLLOW-UP home visit, BRIEF; e.g., routine injection, minimal dressing, etc.....	1.5
9014 FOLLOW-UP home visit, ROUTINE.....	2.0
†9015 FOLLOW-UP home visit necessitating professional care OVER AND ABOVE routine visit.....	3.0
†9017 FOLLOW-UP home visit necessitating COMPLETE re-examination and re-evaluation of patient as a whole (continuing illness).....	8.5
9018 Home visit each additional member of same household	1.0

HOSPITAL VISITS

9020 INITIAL hospital visit, ROUTINE history and physical examination, including initiation of diagnostic and treatment programs and preparation of hospital records	3.0
†9021 INITIAL hospital visit, COMPLETE diagnostic history and physical examination, ESTABLISHED PATIENT OR MINOR CHRONIC ILLNESS, including initiation of diagnostic and treatment programs and preparation of hospital records.....	5.0
†9022 INITIAL hospital visit, COMPLETE diagnostic history and physical examination, NEW PATIENT OR MAJOR ILLNESS, including initiation of diagnostic and treatment programs and preparation of hospital records	6.0
9024 FOLLOW-UP hospital visit, ROUTINE.....	1.0
†9025 FOLLOW-UP hospital visit necessitating care OVER AND ABOVE routine visit.....	2.0
†9027 FOLLOW-UP hospital visit necessitating COMPLETE re-examination and re-evaluation of patient as a whole	3.0

CONSULTATIONS

A CONSULTATION is considered here to include those services rendered by a physician whose OPINION or ADVICE is requested by another physician or an agency in the evaluation and/or treatment of a patient's illness. When the consultant physi-

15. Other health services: The criteria applicable to the customary charge and prevailing charge also apply to charges for other health services such as; services for ambulance services, durable medical equipment (whether purchased or rented), independent laboratory services, prosthetic devices, injections, etc. In the following paragraphs we shall examine some of these services in detail.

Ambulance services - Medicare pays for ambulance services on the basis of the standard customary and prevailing charge criteria. Ambulance companies may charge for their services on the basis of: (a) a base rate - a dollar amount for the pick-up and delivery of a patient, within a fixed geographical area; and/or (b) mileage - a dollar amount for each mile from the firm business location to the location of the patient. Ambulance services may be provided by a number of different organizations and this has an influence on the fees charged. Such suppliers are: (a) independent commercial operations which must charge a fee high enough to stay in business, (b) municipal and/or volunteer companies, which may provide their services free or for donations only, and (c) funeral homes which by using the same vehicles, garages, etc., have lower operating costs and therefore charge lower fees.

Durable medical equipment - Durable medical equipment is equipment which (a) can withstand repeated use, and (b) is primarily and customarily used to serve a medical purpose, and (c) generally is not useful to a person in the absence of an illness or injury, and (d) is appropriate for use in the home. All requirements of the definition must be met before an item can be considered to be durable medical equipment. Payment for durable medical equipment is made according to the standard customary and prevailing charge criteria. One problem in establishing reasonable charge screens has been the literally thousands of items of durable medical equipment available, the many manufacturers of such goods, and the price variations within each generic type of item.

Independent laboratory services - The patient receiving laboratory services may be billed directly by the physician who performs his own laboratory services or who obtains services from an independent laboratory or another physician's laboratory. The patient may also be billed directly by an independent laboratory for services it has performed. The reasonable charge determination for the laboratory services is based on the customary charge made by the physician or other person rendering the laboratory service and on the prevailing charge in the locality for these services.

The chief difficulty with determining reasonable charges for these services lies in determining the customary charge for automated tests. Under this arrangement up to 24 separate tests can be performed at one time, usually for extremely small cost. Typical charges for such a group of tests (called profiles or batteries) would be \$5 to \$12, whereas the typical charges for these tests if performed individually would be from \$25 to \$120. In order to determine a reasonable charge carriers are instructed to establish the laboratory's customary charge as the charge made to the physician by the laboratory plus a small handling charge designed to cover the expenses incurred by the physician in drawing and preparing the specimen where it is the acceptable medical practice in the locality to make such a separate charge for handling.

Prosthetic devices - A prosthetic device is one which replaces all or part of an internal body organ, or replaces all or part of the function of a permanently inoperative or malfunctioning internal body organ. By and large prosthetic devices are fitted to the individual patient. As a result many prosthetic devices furnished to Medicare beneficiaries are custom made and fitted. For this reason the reasonable charge for such items is often determined on a case-by-case basis.

Injections - Where a separate charge for an injection is submitted by a physician, and it is the prevailing practice in the community to make such an additional charge, the maximum allowable charge may not normally exceed the approximate ingredient and supply cost plus a \$2 allowance for the injection service. Reasonable charge screens for injections should therefore be based on: (1) a flat \$2 amount for the service of the physician (or his office nurse) in providing the injection; plus (2) the current cost of the most frequently administered dosage of the drug, as reflected in sources such as Drug Topics Red Book or the Blue Book, (the latest editions), and the cost of supplies such as syringes and needles. However, in cases involving unusual circumstances, an additional allowance above the \$2 amount for the physician services may be considered provided proper documentation is supplied. For example, injections such as those that require the precise placement of a needle into inflamed, painful, or target areas or the injection of dangerous drugs may require that only a physician provide this service. Consequently, injections of this nature should not be considered routine and appropriate allowances should be made. In these instances, the carrier may establish customary and prevailing charge screens to reflect the actual practice of physicians in a locality.

Chronic Renal Disease Program - Patients with end-stage renal disease are covered by Medicare but some of the payments for the complex medical services they receive are not based on the usual customary

and prevailing charge rules. Special program allowances are applied to outpatient maintenance dialysis treatments that are performed either inside or outside a hospital. In addition, there are payment limitations for some of the services physicians provide to patients receiving maintenance dialysis and surgeons provide to patients undergoing a kidney transplantation operation. (See the Handbook, "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services," for a further discussion of these payments.)

16. The Medicare Act, in section 1842(b)(3)(B), specifies that the reasonable charge for a service may not be higher than the charge applicable for a comparable service under comparable circumstances to the carrier's own policyholders and subscribers. In practice, the term "comparability" has been interpreted rather strictly by Medicare carriers. New guidelines to provide a more universal application of comparability are therefore now being formulated.

PART 3 - GLOSSARY

GLOSSARY OF TERMS

ACTUAL CHARGE A charge made by a physician or other supplier of Part B medical services, which is the basic data used in the determination of reasonable charges.

ARRAY The term describing an ordered arrangement of charge data in the carriers' files. For reasonable charge purposes it implies an ascending order of charges (i.e., the lowest amount at the top and the highest amount at the bottom).

ASSIGNMENT A method of Medicare payment in which the physician or other supplier of Part B services applies directly to the carrier for reimbursement (with the beneficiary's approval). It constitutes an agreement by the physician (or other supplier) that his total charge will not exceed the carrier's determination of the reasonable charge. The beneficiary is responsible only for any of the Part B annual deductible not yet met, plus 20 percent of the balance of the reasonable charge. The beneficiary cannot be billed for the difference between the submitted charge and the reasonable charge.

BASE YEAR AND CALENDAR YEAR Carriers develop revised customary and prevailing charge screens after the end of the calendar year, based upon all available charge data for services during all of that calendar year (January 1 through December 31). They implement these screens at the beginning of the following fee screen year.

Example: The base year for rates effective with the beginning of fee screen year 1977 (7-1-76) is the calendar year 1-1-75 through 12-31-75.

CARRIER A commercial insurance firm or Blue Shield plan administering Part B of Medicare. It is distinguished from commercial insurance plans or Blue Cross plans administering Part A which are referred to as intermediaries.

CHARGE DATA The statistics on actual charges collected from submitted claims (and all other available sources) and used as the bases for the carriers' computations of the customary, prevailing, and reasonable charges.

COINSURANCE A provision by which the insured person shares part of his own medical expenses. In reasonable charge discussions it refers to the 20 percent of reasonable charges for which the Medicare beneficiary is responsible after the Part B annual deductible has been met.

COMPARABILITY PROVISION A provision of the Medicare Act specifying that the reasonable charge for a service may not be higher than the charges applicable for comparable services and under comparable circumstances to the carriers' own policyholders and subscribers.

COVERED SERVICES The term used to describe the medical and other health services for which Medicare Part B payment can be made.

CUSTOMARY CHARGE The amount computed by the carrier based on actual charge data for a specific service performed by one physician (or supplier) to his patients in general. It is a computation essential to the determination of the reasonable charge in a given claim.

DEDUCTIBLE The portion of reasonable charges (for covered services each calendar year) for which a beneficiary is responsible before his benefits begin. For Medicare, currently, it refers to the first \$60 of incurred expenses in a calendar year determined to be reasonable charges by the carrier.

DURABLE MEDICAL EQUIPMENT Equipment which can stand repeated use, is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of illness or injury.

ECONOMIC INDEX A cumulative figure representing changes in physicians' costs of practice and changes in general earnings levels which acts as a ceiling on increases in prevailing charges for physicians' services.

FEE SCREENS Another term describing the customary, prevailing, and reasonable charge amounts established by the carrier at the beginning of each fiscal year. It implies that charges (or fees) in excess of these computed rates are "screened out."

FEE SCREEN YEAR Within the meaning of reasonable charge discussions, the fee screen year, beginning in 1976, runs from July 1 of any calendar year through June 30 of the following calendar year. Example: Fee screen year 1977 begins July 1, 1976, and runs through June 30, 1977.

GENERAL PRACTITIONER A doctor of medicine who generally performs a wide range of medical services as opposed to one who specializes only in certain areas (see Specialist).

HISTORY FILE A listing of charges collected from submitted claims (SSA 1490's) on a specific physician or other supplier, arranged in ascending order, and used in the computation of the customary, prevailing, and reasonable charges.

LOCALITY For the purpose of making reasonable charge determinations, a locality is identified as a geographic area for which a carrier derives the prevailing charges for services. Usually, a locality is a political or economic subdivision of a State which should include a cross-section of the population with respect to economic and other characteristics.

MEDIAN The statistical term indicating the midpoint in an array of charge data. The median charge is the lowest charge below which at least 50 percent of the actual charges fall.

"OTHER" SUPPLIERS The term used to describe nonphysician suppliers of covered Part B medical services and supplies under Medicare.

Examples: ambulance companies, drug stores dealing in wheelchairs, crutches, etc.

PERCENTILE The value in an array of data below which a given percentage of the items in the array fall. For example, in determining the prevailing charge for a service, carriers calculate the 75th percentile of the array of customary charges for the service (see Prevailing Charge).

PREVAILING CHARGE Generally, the lowest charge on an array of customary charges which is high enough to include 75 percent of all the customary charges.

PROFILE The term describing the carrier's record of calculated customary charges for each physician and supplier of Part B medical services.

PROSTHETIC DEVICE A device which replaces all or part of an internal body organ, or all or part of the function of a permanently inoperative or malfunctioning internal body organ. Examples: An artificial leg, cataract lenses, a cardiac pacemaker.

REASONABLE CHARGE An individual charge determination made by a carrier on a covered Part B medical service or supply. In the absence of unusual medical complications or circumstances it is the lowest of 1) the physician's or other person's customary charge for that service; 2) the prevailing charge for similar services in the locality; and 3) the actual charge of the physician or other person rendering the service.

RELATIVE VALUE STUDY (RVS) A method by which certain medical societies have identified the relative value of each procedure or service provided by physicians in relation to the values of other services. Where there is no reliable statistical basis for determining the customary charge of a physician or other person for a particular medical procedure or service, or for determining the prevailing charge, the carrier may develop or use an existing relative value study.

SPECIALIST A physician who works primarily in a certain area of medicine; e.g., neurosurgery, ophthalmology, urology, internal medicine, general surgery. A specialist may be so designated because of board eligibility, board certification, or because of his own restriction of his practice to a certain specialty.

UNUSUAL CIRCUMSTANCES Medical complications or other circumstances requiring additional time, effort or expense to such an extent that the service is essentially different from the usual. These "unusual circumstances" may justify payment in excess of the established customary or prevailing charges for the more common service.

UPDATING A term describing the revision of customary, prevailing, and reasonable charge screens, using a new base year's charge data. It takes place at the beginning of each fee screen year, or as soon thereafter as the new screens can be incorporated into the carrier's claims processes.

WEIGHTING Recognizing the number of times each value occurs in a distribution. This permits each value to express its individual effect on a calculation. For example, in establishing the prevailing charge for a particular procedure, the carrier weights each calculated customary charge by how often the procedure was performed by that provider.

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